



Dear Patient:

Enclosed in the letter you will find our new patient paperwork. We ask that you complete the paperwork prior to your appointment and return it to our office at least three days before your scheduled appointment. If we do not have your completed paperwork you may be asked to reschedule your appointment. If you have any questions, please phone us at 864-482-2350. You will receive a reminder call approximately 1 day before your appointment.

Appointment checklist: (please be sure to bring to your appointment)

_____ Completed paperwork

_____ Detailed medication list completed (prescription and over the counter medications) or you may bring your medications in their original bottles with you.

_____ Insurance card(s) and a picture ID

Your appointment is scheduled for _____ at _____ am/pm with
Dr. _____.

***Copays will be collected at the time of your appointment.

Thank you,

Oconee Heart Center



Welcome To Our Practice

We would like to take this opportunity to welcome you to our practice, and look forward to the privilege of meeting your health care needs. Please don't hesitate to let us know at any time if we are not meeting your needs or if you have questions. We have a satisfaction survey that we would like for you to complete after your visit. This will allow us to know how we can better improve our service.

As a member of Oconee Physician Practices and an affiliated health partner with Oconee Medical Center; we are dedicated to providing high quality health care. We are a local non-profit medical group sponsored by the hospital. As a result, any bill you receive from us will have the name of **Oconee Physician Practices** as well as your physician name versus the name of this individual practice location.

For your convenience, you may pay any open balances from other practices affiliated with Oconee Physician Practices at any of our locations.

Please find below a list of all our practices:

Between the Lakes Primary Care
Blue Ridge Women's Center
Clemson-Seneca Pediatrics
Keowee Family Urology
Mountain Lakes ENT and Allergy Center
Mountain Lakes Internal Medicine
Oconee Heart Center
Oconee Kidney Center
Oconee Multi-Specialty Clinic
Rheumatology Consultants
Seneca Medical Associates
Upstate Family Medicine
Upstate Surgical Associates



HOW TO PREPARE FOR YOUR NEW PATIENT VISIT

The New Patient Pack that you received at our office will need to be filled out completely and returned to our office *at least three days* before your scheduled appointment.

Please be sure to bring all your medication bottles to each of your appointments. This should include all prescription drugs, over the counter medications and/or any herbal remedies you have been taking. Also, we ask that you not wear any oil or lotions and ladies please remove all finger nail polish prior to your appointment.

WHAT TO EXPECT AT YOUR NEW PATIENT VISIT

At check in you will be asked to provide your current insurance card and photo identification. Also be prepared to pay any copayment that is printed on your insurance card at that time.

At every appointment your height, weight, temperature, pulse and blood pressure will be checked. We will go over your medical, family, and social history. The provider will do a limited exam and order any necessary diagnostic tests. A follow up visit will be scheduled for you at check out if necessary.

OFFICE COURTESIES

A 48 business hours notice is required for all call in prescriptions. Please do not wait until you are out of a medication to call for a refill.

If you need to cancel an appointment please call our office 24-48 hours a head of time. This will allow an opening for the physician to see other patients that may be in need of an appointment.

You can reach office staff Monday through Friday between the hours of 8:30 a.m. to 12:00 p.m. and 1:30 p.m. to 5:00 p.m.



Patient Information									
Last Name				Social Sec #					
First Name				Birth Date					
Middle Name				Sex (M or F)					
Street Address				Race					
Suite / Apt #				Primary Language					
City		State		Zip		Marital Status			
Mailing Address				Legal Guardian					
City		State		Zip		Legal Guardian's Primary Phone			
Home Phone			Work Phone			Cell Phone			
Email Address									

Guarantor Information (Person Responsible For Bill)									
Last Name				Social Sec #					
First Name				Birth Date					
Middle Name				Sex (Male or Fem)					
Street Address				Relationship					
City		State		Zip		Home Phone:			
Mailing Address				Work Phone:					
City		State		Zip		Cell Phone:			

Employment Information			
Patient's Employer			Employer Phone
Spouse's Employer			

Emergency Contact Information				
Name		Relationship		Phone

Physician Information			
Name of Family Physician			City/State
Name of Referring Physician			City/State

Insurance Information For Patient– Provide complete and provide copy of insurance card(s)		
Primary Insurance Company:	Name of Insured:	Relationship to Insured:
	Birthday of Insured:	Their Social Security #:
Secondary Insurance Company:	Name of Insured:	Relationship to Insured:
	Birthday of Insured:	Their Social Security #:
Additional Insurance Company:	Name of Insured:	Relationship to Insured:
	Birthday of Insured:	Their Social Security #:

Assignment of Benefits: I hereby authorize payment of medical benefits directly to Oconee Physician Practices for their services and to release any information acquired in the course of my examination or treatment for insurance purposes. I understand that records may be transmitted electronically or by mail as required.

Signature Of Patient Or Guardian >> _____ **Date:** _____

HEALTH HISTORY QUESTIONNAIRE – Adult

Questions contained in this questionnaire are strictly confidential and will become part of your medical record.

BASIC INFORMATION

Patient Name:	Date of Birth:
Last Provider Seen/Date:	
Allergies/Reaction: (<input type="checkbox"/> None)	

PERSONAL HISTORY

CHILDHOOD ILLNESSES	DATES (most recent):	IMMUNIZATIONS	DATES (most recent):	HEALTH MAINTENANCE	DATES (most recent):
<input type="checkbox"/> Measles:		<input type="checkbox"/> Tetanus:		<input type="checkbox"/> Eye Exam:	
<input type="checkbox"/> Mumps:		<input type="checkbox"/> Hepatitis:		<input type="checkbox"/> EGD:	
<input type="checkbox"/> Rubella:		<input type="checkbox"/> Flu:		<input type="checkbox"/> EKG:	
<input type="checkbox"/> Chickenpox:		<input type="checkbox"/> H1N1:		<input type="checkbox"/> Colposcopy:	
<input type="checkbox"/> Rheumatic Fever:		<input type="checkbox"/> Gardasil:		<input type="checkbox"/> Colonoscopy:	
<input type="checkbox"/> Polio:		<input type="checkbox"/> Pneumonia:		<input type="checkbox"/> Bone Density Screening:	
<input type="checkbox"/> Other:		<input type="checkbox"/> Zostavax:		<input type="checkbox"/> Other:	
<input type="checkbox"/> Other:		<input type="checkbox"/> PPD:		<input type="checkbox"/> Other:	
<input type="checkbox"/> Other:		<input type="checkbox"/> Other:		<input type="checkbox"/> Other:	

MEDICAL HISTORY

Please check box labeled C if the problem is Current, and P if the problem occurred in the Past.

C	P	RESPIRATORY/ENT	C	P	CARDIOVASCULAR
		Hearing Problems			High Blood Pressure
		Ringing in Ears			Irregular Pulse
		Prolonged Hoarseness			Fainting Spells
		Sinus Trouble			Swollen Ankles
		Vision Problems			Cold Numb Feet
		Bronchitis			Varicose Veins
		Chronic Cough			Dizzy Spells
		Shortness of Breath			Leg Pain/Fatigue
		Eye Pain			Chest Pain/Pressure
		Nose Bleeds			Palpitations
		Sore Throat			Heart Murmur
		Pneumonia			
		COPD/OSA			C P EMOTIONAL
		Asthma			Depression
		Wheezing			Mental Illness
					Mood Swings
C	P	GASTROINTESTINAL			Thoughts of Death
		Appetite			Sleep Problems
		Difficulty Swallowing			Lack of Concentration
		Bloody/Tar-Like Stool			Decreased Work Performance
		Hepatitis			Anxiety
		Nausea/Vomiting			Bipolar
		Bowl Changes			
		Abdominal Pain			C P URINARY
		Jaundice			>2 Overnight
		Crohn's Disease			Stress Incontinence
		Peptic Ulcer			Kidney Stones
		Gallbladder			Blood in Urine
		Constipation			Urinary Tract Inf.
		Diarrhea			Painful
		Diverticulosis			Low Flow
		Special Diet			Bed Wetting

FEMALES ONLY

Menstrual Flow:
 Regular Irregular Pain/Cramps

Date 1st day of last period:
 Flushing/Menopause

Sexually Active: Sexual Problems:
 Yes No Yes No

Birth Control Method:
 Vaginal C-Section

of Pregnancies: # of Miscarriages:
of Live Births: # of Abortions:

Date of last Pap Smear:
 Normal Abnormal

Date of last Mammogram:
 Normal Abnormal

MALE ONLY

Check all that apply:
 Vasectomy Circumcision Inguinal Hernia

Sexually Active: Sexual Problems:
 Yes No Yes No

Prostate Problems: Last PSA date:
 Yes No

Other:

SURGERIES:



SOCIAL HISTORY QUESTIONNAIRE - (ADULT)

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Date: _____	SOCIAL HISTORY QUESTIONNAIRE - (ADULT) All questions contained in this questionnaire are strictly confidential and will become part of your medical record.
Home # : _____	
Birth date: _____	
<input type="checkbox"/> M <input type="checkbox"/> F	
Name (Last, First, M.I.): _____	

TOBACCO PRODUCTS:

Do you have a history of smoking or currently smoke: Yes No

Type: cigarette cigar pipe

Start Date: _____ End Date: _____

Amount of cigarettes:

less than 1 cigarette/day

light (1-9 cigs/day)

moderate (10-19 cigs/day)

heavy (20-39 cigs/day)

very heavy (40+ cigs/day)

Interested in quitting smoking: yes no

STOP DATE: _____

Smokeless:

Do you have a history with smokeless tobacco or currently use:

Yes No

Type: chew snuff powder

Start Date: _____ End Date: _____

Amount: _____

Interested in quitting smokeless:

yes no

STOP DATE: _____

Comments: _____

ALCOHOL USE:

Non-drinker

Current alcohol user

Type: beer hard liquor wine

Average drinks/week: _____

Drinks/day on typical drinking day: _____

High risk alcohol use: yes

Binge drinker: yes

Past heavy use: yes

Patient has been in an alcohol treatment program: yes no

Comments: _____

CAFFEINE USE:

No caffeine use

Uses caffeine

Type: coffee tea soda

energy drinks caffeine supplements

Total Amount:

excessive (equiv to 10+ 8oz coffee/day)

heavy (equiv to 4-9 8oz coffee/day)

moderate (equiv to 1-3 8oz coffee/day)

minimal (equiv to < 1 8oz coffee/day)

Comments: _____

DIET NUTRITION:

Difficulty chewing: yes

Difficulty swallowing: yes

History of eating disorder: yes

Financial issues affecting the ability to buy the needed food: yes

Special diet:

diabetic gluten free low fat

low sodium renal vegan

vegetarian weight reduction other

Comments: _____

ENVIRONMENT:

Lives alone yes no

Patient/Person Completing Form: _____

Relationship: _____

FAMILY HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

BASIC INFORMATION

Patient Name:	Date of Birth:	Today's date:
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FAMILY HISTORY

Please check the box and circle the family member's code that had any of the items listed below.

M=Mother **F**=Father **B**=Brother **S**=Sister **MGF**=Maternal Grandfather **MGM**=Maternal Grandmother **PGF**=Paternal Grandfather **PGM**=Paternal Grandmother

Heart/Cardiovascular		Mental Health
Angina/Chest Pain/CAD: <input type="checkbox"/> Y <input type="checkbox"/> N	M F B S MGF MGM PGF PGM	Alcoholism: <input type="checkbox"/> Y <input type="checkbox"/> N M F B S MGF MGM PGF PGM
Heart Attack/Heart Disease: <input type="checkbox"/> Y <input type="checkbox"/> N	M F B S MGF MGM PGF PGM	Attention Deficit Disorder: <input type="checkbox"/> Y <input type="checkbox"/> N M F B S MGF MGM PGF PGM
High Cholesterol: <input type="checkbox"/> Y <input type="checkbox"/> N	M F B S MGF MGM PGF PGM	Bipolar Disorder: <input type="checkbox"/> Y <input type="checkbox"/> N M F B S MGF MGM PGF PGM
High Triglycerides: <input type="checkbox"/> Y <input type="checkbox"/> N	M F B S MGF MGM PGF PGM	Depressive Disorder: <input type="checkbox"/> Y <input type="checkbox"/> N M F B S MGF MGM PGF PGM
High Blood Pressure: <input type="checkbox"/> Y <input type="checkbox"/> N	M F B S MGF MGM PGF PGM	Mental Disorder: <input type="checkbox"/> Y <input type="checkbox"/> N M F B S MGF MGM PGF PGM
Ischemic Heart Disease: <input type="checkbox"/> Y <input type="checkbox"/> N	M F B S MGF MGM PGF PGM	Schizophrenia: <input type="checkbox"/> Y <input type="checkbox"/> N M F B S MGF MGM PGF PGM
Sudden Death: <input type="checkbox"/> Y <input type="checkbox"/> N	M F B S MGF MGM PGF PGM	<input type="checkbox"/> Other: M F B S MGF MGM PGF PGM
PVD/AAA <input type="checkbox"/> Y <input type="checkbox"/> N	M F B S MGF MGM PGF PGM	Musculoskeletal
Blockage of Arteries Location(s): _____ <input type="checkbox"/> Y <input type="checkbox"/> N	M F B S MGF MGM PGF PGM	Osteoarthritis: <input type="checkbox"/> Y <input type="checkbox"/> N M F B S MGF MGM PGF PGM
Aneurysm: _____ <input type="checkbox"/> Y <input type="checkbox"/> N	M F B S MGF MGM PGF PGM	Rheumatoid Arthritis: <input type="checkbox"/> Y <input type="checkbox"/> N M F B S MGF MGM PGF PGM
Endocrine/Metabolic		Osteoporosis: <input type="checkbox"/> Y <input type="checkbox"/> N M F B S MGF MGM PGF PGM
Diabetes Mellitus: <input type="checkbox"/> Y <input type="checkbox"/> N	M F B S MGF MGM PGF PGM	Multiple Sclerosis: <input type="checkbox"/> Y <input type="checkbox"/> N M F B S MGF MGM PGF PGM
Thyroid Disorder: <input type="checkbox"/> Y <input type="checkbox"/> N	M F B S MGF MGM PGF PGM	Scleroderma: <input type="checkbox"/> Y <input type="checkbox"/> N M F B S MGF MGM PGF PGM
<input type="checkbox"/> Other: M F B S MGF MGM PGF PGM		Lupus: <input type="checkbox"/> Y <input type="checkbox"/> N M F B S MGF MGM PGF PGM
		<input type="checkbox"/> Other: M F B S MGF MGM PGF PGM
Eyes/Ears/Nose/Throat		Neurologic
Glaucoma: <input type="checkbox"/> Y <input type="checkbox"/> N	M F B S MGF MGM PGF PGM	Alzheimer's disease: <input type="checkbox"/> Y <input type="checkbox"/> N M F B S MGF MGM PGF PGM
Hearing Loss: <input type="checkbox"/> Y <input type="checkbox"/> N	M F B S MGF MGM PGF PGM	Dementia: <input type="checkbox"/> Y <input type="checkbox"/> N M F B S MGF MGM PGF PGM
Loss of Vision: <input type="checkbox"/> Y <input type="checkbox"/> N	M F B S MGF MGM PGF PGM	Migraine: <input type="checkbox"/> Y <input type="checkbox"/> N M F B S MGF MGM PGF PGM
<input type="checkbox"/> Other: M F B S MGF MGM PGF PGM		Stroke: <input type="checkbox"/> Y <input type="checkbox"/> N M F B S MGF MGM PGF PGM
		<input type="checkbox"/> Other: M F B S MGF MGM PGF PGM
Genetic/Birth		Oncologic
Birth Defects: <input type="checkbox"/> Y <input type="checkbox"/> N	M F B S MGF MGM PGF PGM	Melanoma: <input type="checkbox"/> Y <input type="checkbox"/> N M F B S MGF MGM PGF PGM
<input type="checkbox"/> Other: M F B S MGF MGM PGF PGM		Ovarian Cancer: <input type="checkbox"/> Y <input type="checkbox"/> N M F B S MGF MGM PGF PGM
Genitourinary		Prostate Cancer: <input type="checkbox"/> Y <input type="checkbox"/> N M F B S MGF MGM PGF PGM
Endometriosis: <input type="checkbox"/> Y <input type="checkbox"/> N	M F B S MGF MGM PGF PGM	Skin Cancer: <input type="checkbox"/> Y <input type="checkbox"/> N M F B S MGF MGM PGF PGM
Kidney Disease: <input type="checkbox"/> Y <input type="checkbox"/> N	M F B S MGF MGM PGF PGM	Stomach Cancer: <input type="checkbox"/> Y <input type="checkbox"/> N M F B S MGF MGM PGF PGM
Ovary Disease: <input type="checkbox"/> Y <input type="checkbox"/> N	M F B S MGF MGM PGF PGM	<input type="checkbox"/> Other: M F B S MGF MGM PGF PGM
Toxemia of Pregnancy: <input type="checkbox"/> Y <input type="checkbox"/> N	M F B S MGF MGM PGF PGM	Respiratory
<input type="checkbox"/> Other: M F B S MGF MGM PGF PGM		Asthma: <input type="checkbox"/> Y <input type="checkbox"/> N M F B S MGF MGM PGF PGM
Blood/Hematologic		Pulmonary Embolism: <input type="checkbox"/> Y <input type="checkbox"/> N M F B S MGF MGM PGF PGM
Clotting Disorder: <input type="checkbox"/> Y <input type="checkbox"/> N	M F B S MGF MGM PGF PGM	COPD/Emphysema: <input type="checkbox"/> Y <input type="checkbox"/> N M F B S MGF MGM PGF PGM
Anemia: <input type="checkbox"/> Y <input type="checkbox"/> N	M F B S MGF MGM PGF PGM	Cystic Fibrosis: <input type="checkbox"/> Y <input type="checkbox"/> N M F B S MGF MGM PGF PGM
Leukemia: <input type="checkbox"/> Y <input type="checkbox"/> N	M F B S MGF MGM PGF PGM	Sleep Apnea: <input type="checkbox"/> Y <input type="checkbox"/> N M F B S MGF MGM PGF PGM
Lymphoma: <input type="checkbox"/> Y <input type="checkbox"/> N	M F B S MGF MGM PGF PGM	Tuberculosis: <input type="checkbox"/> Y <input type="checkbox"/> N M F B S MGF MGM PGF PGM
Hemophilia: <input type="checkbox"/> Y <input type="checkbox"/> N	M F B S MGF MGM PGF PGM	<input type="checkbox"/> Other: M F B S MGF MGM PGF PGM
Sickle Cell Anemia: <input type="checkbox"/> Y <input type="checkbox"/> N	M F B S MGF MGM PGF PGM	

Additional Comments: _____

Person Completing Form: _____



- Between the Lakes
- Blue Ridge Women’s Center
- Clemson-Seneca Pediatrics
- Keowee Family Urology
- Mountain Lakes ENT and Allergy Center
- Mountain Lakes Internal Medicine
- Oconee Heart Center
- Oconee Kidney Center
- Rheumatology Consultants
- Seneca Medical Associates
- Upstate Family Medicine
- Upstate Surgical Associates

Release of Information Authorization Form

Acknowledgement of Receipt of Notice of Privacy Practices and Financial Policy

This signed form acknowledges that you have received a copy of our practice’s Notice of Privacy Practices as required by Federal Law and our Financial Policy. By signing below you are acknowledging that you understand and have read the notices. The notices are yours to keep.

With whom may we discuss patient’s financial information?

Patient Only: []

Name: _____ Relationship: _____
For patient over age of 18 only

Name: _____ Relationship: _____
For patient over age of 18 only

May we leave messages regarding appointments?

(Messages regarding any other information will be left as call back request only)

- YES _____
What Phone Number
- NO

With whom may we discuss patient’s medical information?

Patient Only: []

Name: _____ Relationship: _____
For patient over age of 18 only

Name: _____ Relationship: _____
For patient over age of 18 only

Print Patient Name

Patient Date of Birth

 Signature of Guarantor/ Patient/ Legal Guardian

 Date

This authorization is in effect until revoked in writing.



FINANCIAL POLICY

COLLECTION OF PATIENT AMOUNTS DUE

Insurance companies require that we collect any co-pay or co-insurance amounts at the time of service. We will collect the co-pay amounts at the time of check-in to avoid a wait at check-out. All co-insurance amounts will be collected at the time of check-out. Please understand that you will be responsible for any amounts not paid by your insurance company. OPP also offers a 20% discount to uninsured patients if the balance is paid at the time of service or within 30 days of the visit.

We understand that temporary financial problems may effect timely payment of your balance. We encourage you to communicate any such problems so that we may assist you in the management of your account.

We understand that there may be special agreements between parents regarding a child's medical expenses. However, the parent that brings the child in for a visit is responsible for making payment on that date of service.

PRESCRIPTION REFILL REQUESTS BY PHONE

We will generally need to see an existing patient back in the office prior to calling in a prescription. However, in rare cases where it's appropriate to write the prescription, there will be a \$15.00 charge in order to cover operating costs. This is not generally covered by your insurance.

DISMISSAL OF PATIENTS FOR FINANCIAL REASONS

Patients can be dismissed from the practice for a number of reasons, including the following financial situations:

1. Collection Agency Turnover will result in a dismissal from the practice if a patient fails to pay his or her balance within thirty days of turnover.
2. Expedited dismissal occurs when a patient is not honoring his or her financial responsibilities.

All patients should be given at least thirty days notice before being dismissed from practice unless instructed otherwise by physician.

This notice is yours to keep.